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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01761

Reg. Dist. No. 200

1. PLACE OF DEATH:

County Kent
 City or town Salma
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all life
 Hospital, institution, or street address where death occurred: Shirley Hill
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Salma
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Shirley Hill
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Sarah Emma Chambers

3. (b) Social Security Number

4. Sex Female 5. Color or race Ch. 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife (late) James Chambers
 7. Birth date of deceased (mo., day, yr.) November 30 1881 6. (c) If alive, give age _____ years
 8. AGE: Years 66 Months 3 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Salma Kent Co. Maryland
(To, county, and state)10. Usual occupation Housekeeping11. Industry or business home

12. Name Thomas Brown
 13. Birthplace Kent Co. Maryland
 14. Maiden name Mary Jane Wilson
 15. Birthplace Kent Co. Maryland

16. Informant William Butler
 Address Salma, Kent Co. Maryland

17. Burial Date thereof Feb. 28/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Shirley Hill

Location near Salma, Kent Co. Maryland
 18. Funeral director Marvin V. Williamson
 Address Chesapeake, Maryland

19. Feb. 28 19 48 Elizabeth J. Muford
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 19 48 at 6:30 A.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 23 19 48 to February 26 19 48
 and that I last saw him alive on February 23 19 48

Immediate cause of death Hypertensive
and atherosclerotic
heart disease

DURATION

2 yrs.

Due to

Due to

Other conditions generalized arterio-
sclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Shedue F. Paprocki M.D.Address Salma, Md. Date signed 2-27-48

M. D. or other

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MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 204

1. PLACE OF DEATH:

County Kent
 City or town Worton Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life home
 Hospital, institution, or street address where death occurred:
2nd
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Worton Point
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Worton R.R. 2nd
 (If rural, give LOCATION)
 2(a) If veteran, name war 2nd

3. (a) FULL NAME

Gertrude Comegga

3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife George Comegga

7. Birth date of deceased (mo., day, yr.) January 7 - 1884 6. (c) If alive, give age 64 years

8. AGE: Years 64 Months 1 Days 17 If less than one day hrs. min.

9. Birthplace Kent Co. Md.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name John Munro

13. Birthplace Kent Co. Md.

14. Maiden name Gertrude Munro

15. Birthplace Kent Co. Md.

16. Informant George Comegga

Address Worton Rd.

17. Date thereof Feb 27 1948

(Burial, cremation, or other? Which?) (month) (day) (year)

Cemetery or crematory Burial George K.C. & M.H.

Location Worton Point

18. Funeral director Asbury H. Hays

Address Chesterton

19. Date rec'd by registrar Feb 27 1948

Registrar H. H. Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 19 48 at 6:28 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to Feb 24 1948 and that I last saw him alive on Feb 23 19 48

Immediate cause of death Nephritis

Due to Chronic

Other conditions Chronic

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

Other conditions

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Other conditions

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Other conditions

Other conditions

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MAR 2 1948

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01763 282

1. PLACE OF DEATH:

County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
8 years
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Water St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Frances B. Denton

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife none
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept. 11, 1870
 8. AGE: Years 77 Months 5 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Texas
 (Town, county, and state)
 10. Usual occupation Secretary
 11. Industry or business _____
 12. Name Dr. Ashley N. Denton
 13. Birthplace Texas
 14. Maiden name Margaret Murchison
 15. Birthplace Mississippi

16. Informant Mrs. Mildred Wells
 Address Chestertown, Md
 17. Burial Date thereof Feb. 28, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Paul
 Location near - Chestertown, Md.
 18. Funeral director J. Willis Wells
 Address Chestertown, Md.

19. Feb. 26, 1948 Clara L. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21, 1948 at 3:30 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1947 to Feb 21, 1948
 and that I last saw him alive on Feb 28, 1948

Immediate cause of death Malnutrition
 Due to prolonged
stomach pain
 Due to over eating
and general malnutrition
 Other conditions of abdominal viscera
 (Include pregnancy within 3 months of death)
 Major findings of operations none
 Date of op. _____
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____
 Where did injury occur? none
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury none Injured at work? _____
 23. SIGNATURE Clara L. Barnes M. D. or other _____
 Address Chestertown, Md Date signed Feb 26, 1948

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 200

01764

1. PLACE OF DEATH:

County Kent

City or town Mar. Massey
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, or divorced

Married

6. (b) Name of husband or wife

Fannie Dixon

7. Birth date of

deceased (mo., day, yr.)

Aug. 31, 1872

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

75

hrs.

min.

9. Birthplace

Cal. Md.
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Joseph Dixon Jr.

12. Name

13. Birthplace

14. Maiden name Jane Williams

15. Birthplace

16. Informant Mrs. Fannie Dixon,

Address Galena, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 12, 1948

(month) (day) (year)

Cemetery or crematory Galena

Location Galena, Md.

18. Funeral director Edward Holloway

Address Mullington, Md.

19. Feb. 11, 1948

(Date rec'd by registrar)

Registrar Edward Holloway

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town Galena
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1948, at 10:30 a.m.

21. I CERTIFY that death occurred on the date above stated that I attended deceased from

Feb. 4, 1947, to Feb. 9, 1948

and that I last saw him alive on Feb. 7, 1948

Immediate cause of death

Coronary
occlusion

Due to

Arterio-sclerosis

Due to

Other conditions

Gen. Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE

Address

Date signed 2/11/48

M. D. or other

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FEB 16 1948
BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County KentCity or town Rural Chesterville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County KentCity or town Rural Chesterville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex FEMALE Color or race Col.6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife William E. Duckery7. Birth date of deceased (mo., day, yr.) April 18 - 1872

6.(c) If alive, give age _____ years

8. AGE: Years 75 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name _____

13. Birthplace _____

14. Maiden name Rachel Cunningham15. Birthplace Wilm. Del.16. Informant Harry Duckery (son)Address Rural Chesterville Md.17. Burial Date thereof Feb. 9, 1948
(Burial, cremation, or removal, write (month) (year))Cemetery or crematory Chesterville Cem.Location Rural Chesterville Md.18. Funeral director Edward FellowsAddress Millington Md.19. Feb. 9 19 48 Edward Fellows
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 19 48 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 19 47 to Feb 4 19 48and that I last saw her alive on Feb 4 19 48Immediate cause of death stroke

DURATION

Due to arterio sclerosis

Due to _____

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. H. Hamilton M. D. or other _____Address Millington Md. Date signed 2/8/48

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FEB 12 1948

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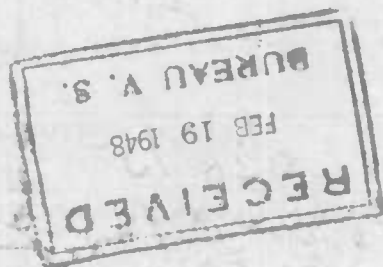
Reg. Dist. No. 200

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County <u>Montgomery</u> City or town <u>W. Helena</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>all life</u> Hospital, institution, or street address where death occurred: How long in hospital or institution? <u>no</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Montgomery</u> County <u>Montgomery</u> City or town <u>W. Helena</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>no</u> (If Rural, give LOCATION) 2.(a) If veteran, name war _____			
3. (a) FULL NAME <u>Samuel Earl Gleason</u>				3. (b) Social Security Number <u>078-03-1410</u>			
4. Sex <u>Male</u>		5. Color or race <u>Caucasian</u>		6. (a) Single, married, widowed, or divorced <u>Single</u>			
6. (b) Name of husband or wife _____				7. Birth date of deceased (mo., day, yr.) <u>July 14, 1902</u>			
8. AGE: <u>45</u> Years <u>7</u> Months <u>1</u> Days If less than one day _____ hrs. _____ min.		8. (c) If alive, give age _____ years					
9. Birthplace <u>W. Helena, Md.</u> (Town, county, and state)							
10. Usual occupation <u>laborer</u>							
11. Industry or business <u>Construction Work</u>							
12. Name <u>Samuel Earl Gleason</u>							
13. Birthplace <u>W. Helena, Md.</u>							
14. Maiden name <u>W. Gleason</u>							
15. Birthplace <u>W. Helena, Md.</u>							
16. Informant <u>Samuel Earl Gleason (mother)</u> Address <u>2012 N. 1st St.</u>							
17. Burial (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof <u>Feb. 15, 1948</u> (month) (day) (year) Cemetery or crematory <u>Oliver Hill</u> <u>W. Helena, Md.</u> Location <u>Edward Fellows</u> <u>Millington, Md.</u>							
18. Funeral director <u>Edward Fellows</u> Address <u>Millington, Md.</u>							
19. Date rec'd by registrar <u>Feb. 18, 1948</u> <u>Elizabeth M. ...</u> <u>Local Registrar</u>							
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Feb 15</u> 19 <u>48</u> at <u>9:30 P.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ and that last seen _____ alive on _____ Immediate cause of death <u>Deep prob. med. abortion</u> Due to <u>Placental</u> Due to <u>abortion</u> Other conditions _____ (Include pregnancy within 3 months of death) Major findings of operations <u>None</u> Date of op. _____ Autopsy results <u>no</u> PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____ 23. SIGNATURE <u>Frank ...</u> <u>med. officer</u> <u>W. Helena, Md.</u> Address <u>W. Helena, Md.</u> Date signed <u>Feb 15, 1948</u>							



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Kent
 City or town Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
sharp town
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Emma Hazelton

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. () Single, married, widowed, or divorced widowed
 8. (b) Name of husband or wife Alexander Hazelton
 8. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) about 1870
 8. AGE: Years about 78 Months Days If less than one day hrs. min.

9. Birthplace Rock Hall, Md
 (Town, county, and state)
 10. Usual occupation housework
 11. Industry or business
 12. Name Hazelton, a.e.b.
 13. Birthplace not known
 14. Maiden name Emma Pines
 15. Birthplace not known

16. Informant Helen Harris
 Address Rock Hall, Md
 17. Burial Date thereof Feb 22 - 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory sharp town
 Location near Rock Hall Md
 18. Funeral director Edgar L. Lane
 Address Church Hill Md
 19. 2/22 19 48 S. Elwood Burgess
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 19 48 at 2:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 20 19 48 to February 19 19 48
 and that I last saw him alive on 2-15 19 48
 Immediate cause of death chronic Emphysema - Myocarditis
decompensation
 Due to arteriosclerosis
hypertension
 Due to paralysis of right
side
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Albert A. Burgess M. D. or other
Rock Hall, Md Date signed 2/9/48
 Address Date signed

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MAR 3 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 201

I. PLACE OF DEATH:

County Cent.City or town Betherton md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Betherton md

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Earnest W. Horsey

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced married.6. (b) Name of husband or wife Mrs. Minnie E. Horsey7. Birth date of deceased (mo., day, yr.) Nov 7 18756. (c) If alive, give age 58 years8. AGE: Years 77 Months 1 Days 24 It less than one day _____ hrs. _____ min.9. Birthplace Wileware

(Town, county, and state)

10. Usual occupation clerk11. Industry or business Lumber & Hardware.12. Name William T. Horsey13. Birthplace Maryland14. Maiden name Mary E. Horsey15. Birthplace Smithville md16. Informant Mrs. Minnie E. HorseyAddress Betherton md17. Burial Date thereof Feb. 5 1948

(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Still Pond mdLocation Still Pond md.18. Funeral director B.R. HollowayAddress Still Pond md.19. Feb 5 1948 Registrar J. Melark

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1948 at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 6 1948 to Feb 1 1948and that I last saw him alive on Feb 1 1948Immediate cause of death Cirrhosis of liverprobably carcinoma.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations XAutopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James Edwin DedmanAddress Betherton Md. Date signed Feb 5-1948

MARGIN RESERVED FOR BINDING

VS A15

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MAR 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

1. PLACE OF DEATH:

County Kent
 City or town Chattahoochee
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

Kent and Chas. Ann. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Rock Hall
(If outside city or town limits, write RURAL and give nearest town)Street No. Chattahoochee Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Margaret V. Hyland

3. (b) Social Security Number

220-26-2922

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

(late) John W. Hyland

7. Birth date of

deceased (mo., day, yr.)

October 2 1874

6. (c) If alive, give age. _____ years

8. AGE:

Years

Months

Days

If less than one day

73413

hrs.

min.

9. Birthplace

Kent Co. Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

MOTHER FATHER

12. Name

James H. Vanzant

13. Birthplace

Cecil Co. Maryland
Chas. Borte

14. Maiden name

Chas. Borte

15. Birthplace

Cecil Co. Maryland

16. Informant

W. O. Kelpster Hyland

Address

Rock Hall, Kent Co. Maryland

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Feb. 18 1948
(month) (day) (year)

Cemetery or crematory

Wesley Chapel

Location

Rock Hall, Maryland

18. Funeral director

Marvin L. Williams

Address

Chattahoochee, Maryland

19.

Feb. 18 1948
(Date rec'd by registrar)

19

48Clara S. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1948, at 6 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 7 1948, to Feb. 15 1948and that I last saw h. 2-15 alive on 1948

Immediate cause of death

Bilateral Bronchopneumonia
Hypertension, arteriosclerosis
chron. Endo - myocarditis

Due to

Due to

Carcinoma of vulva

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? -
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -

23. SIGNATURE

Albert G. Burgess

M. D. or other

Address Rock Hall, Md. Date signed 2/17/48

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FEB 20 1948

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

204

1. PLACE OF DEATH:

County Kent
 City or town Fairfax
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all life
 Hospital, institution, or street address where death occurred:
Fairfax, Kent Co. Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Fairfax
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Clinton Rd.
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

George (Henson) Hynum

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Malecol.Widowed

6. (b) Name of husband or wife

(late) Lucinda Hynum

7. Birth date of deceased (mo., day, yr.)

June 1, 1886

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

61824hrs.min.9. Birthplace Kent Co. Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farm

FATHER MOTHER

12. Name John Hynum13. Birthplace Millets, Kent Co. Md.14. Maiden name unknown15. Birthplace unknown16. Informant Chas. ParkerAddress Fairfax, Kent Co. Maryland17. Burial
(Burial, cremation, or removal. Which?)Date thereof Feb. 27 1948
(month) (day) (year)Cemetery or crematory MilletsLocation Millets, Kent Co. Maryland16. Funeral director Marvin V. WilliamsAddress Charleston, Maryland19. Feb. 27 19 48
(Date rec'd by registrar)J. K. Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 19 48 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
bed not a final diagnosis
and the last cause of death was
Immediate cause of death
underlying cause of death
Duration

Due to MyocardialDue to ArteriosclerosisOther conditions Acute Infectious

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Jones M.D.Address Charleston, Md.Date signed Feb 26 1948

RECEIVED

MAR 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County KentCity or town Rock Hall
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Rock Hall
(If outside city or town limits, write RURAL and give nearest town)Street No. Boundary Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Louis Aubrey Smith

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

m.wh.widowed6. (b) Name of husband or wife Emily Esther Smith7. Birth date of deceased (mo., day, yr.) Aug 27 1856 6. (c) If alive, give age years8. AGE: Years 91 Months 5 Days 6 If less than one day
hrs. min.9. Birthplace Lanham Co. Md.
(Town, county, and state)10. Usual occupation water man retired11. Industry or business self.12. Name not known
13. Birthplace14. Maiden name not known

15. Birthplace

16. Informant Mr Max JacobsAddress Rock Hall Md.17. Burial Date thereof Feb 4 - 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Wesley Chapel CemeteryLocation Rock Hall Md18. Funeral director Edgar L LaneAddress Church Hill Md19. 2/2 19 48 S. Edward Bogan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 19 48 at 6:58 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 48 to Feb 2 19 48
and that I last saw him alive on 1/27 19 48

Immediate cause of death

old agesenile dementiaDue to arteriosclerosischron. suppurative

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

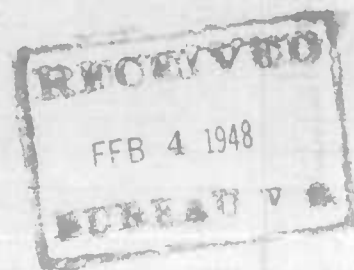
Means of Injury Injured at work?

23. SIGNATURE Albert G. Burgard M. D. or otherAddress Rock Hall Md Date signed 2/2/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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16
L261

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

132

01772

202

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Kent
 City or town Chestertown R.R.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Kent
 City or town Chestertown R.R.
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eula K. States

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Geo. W. States

7. Birth date of deceased (mo., day, yr.) July 22, 1880

8. AGE: Years 67 Months 0 Days 0 If less than one day

8. (c) If alive, give age years

8. AGE: Years 67 Months 0 Days 0 If less than one day

8. AGE: Years 67 Months 0 Days 0 If less than one day

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8. AGE: Years 67 Months 0 Days 0 If less than one day

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8. AGE: Years 67 Months 0 Days 0 If less than one day

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 19 48 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 19 48 to Feb 24 19 48

and that I last saw her alive on Feb 24 19 48

Immediate cause of death Acute Bright's Disease

DURATION

3 mks.

Due to

Due to

Other conditions Paralysis of Throat 2 days.

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. P. Atwell M. D. or otherAddress Steele Pond Date signed 2-25-48

19. Feb. 25 19 48 Clara L. Barnes
 (Date rec'd by registrar) Registrar

RECEIVED

FEB 27 1948

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9.02

1. PLACE OF DEATH:

County.....Kent
 City or town.....Chesapeake
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

col

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

September 25, 1904

8. AGE:

Years

Months

Days

If less than one day

4354

hrs.

min.

9. Birthplace

Chesapeake Virginia
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farmer

FATHER

12. Name

Thomas Temple

13. Birthplace

Virginia

MOTHER

14. Maiden name

Chris Temple

15. Birthplace

Virginia

16. Informant

Jane Green - Cousin of wife

Address

202 Lynnhelm St. - Chesapeake Maryland

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Burial 3/3/48
Chesapeake Co. Alms House

Location

near Chesapeake Kent Co. Maryland

18. Funeral director

Walter V. Williams

Address

Chesapeake Maryland

19.

(Date rec'd by registrar)

19.48

Clara S. Barnes
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Kent

City or town

Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

Street No.

202 Lynnhelm

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

230-01-7397

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Feb 29

19

48

at

8 P M

2E. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him/her alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

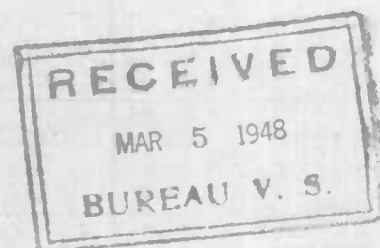
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County Kent
 City or town near - Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town _____
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hettie Greenwood Thompson

3. (b) Social Security Number

no

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife J. Hydrie Thompson

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Mar. 16, 1873

8. AGE:

Years

Months

Days

If less than one day

74II3

hrs.

min.

9. Birthplace Chestertown - Kent Co. Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Henry Greenwood13. Birthplace New JerseyMOTHER 14. Maiden name Lucy Burgess15. Birthplace Maryland16. Informant Mrs. Geo. GriceAddress Rock Hall, Maryland17. Burial Date thereof Feb. 22, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Chestertown xxxxx Cem.Location Chestertown, Md.19. Funeral director J. Willis WellsAddress Chestertown, Md.19. 2/20 19 48 S. Elwood Brinson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 19 48, at 9:20 A M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Feb. 19th, 1948, to Feb. 19, 1948
and that I last saw him er alive on Feb. 19, 1948 19 48Immediate cause of death Cardiac Thrombosis

DURATION

Due to Cardio- Vascular Disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

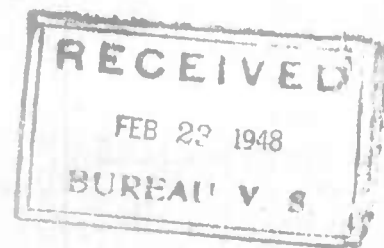
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? _____

23. SIGNATURE Frank N. Smith M. D. or otherAddress Chestertown Date signed 2/19/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County... Kent

City or town... Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?...

Hospital, institution, or street address where death occurred:

Washington Ave.

How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Kent

City or town... Chestertown
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Frederick G. Usilton

3. (b) Social Security Number

213-I6-7906

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife... Addie H. Usilton
living 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1867

8. AGE: Year 80 Month II Days 28 If less than one day hrs. min.

9. Birthplace... Kent County Maryland
(Town, county, and state)

10. Usual occupation... Printer Editor

11. Industry or business Newspaper

12. Name... Wm. B. Usilton

13. Birthplace... Kent Co. Md.

14. Maiden name... Mary Frazier

15. Birthplace... Kent Co. Md.

16. Informant... Mrs. Addie Usilton

Address... Washington Ave. Chestertown, Md.

17. Burial Date thereof... Feb. 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Chester Cem.

Location... Chestertown, Md.

18. Funeral director... J. Willis Wells

Address... Chestertown, Md.

19. Feb. 7 1948 Clara S. Barnes.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1948 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20, 47 to Feb. 6, 1948
and that I last saw him alive on Feb. 6, 1948

Immediate cause of death... Myocarditis DURATION 2 weeks

Due to... Atrio Sclerosis no. of yr

Due to... Apoplexy in Feb. 1947

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations... None Date of op.

Autopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury... None Injured at work?

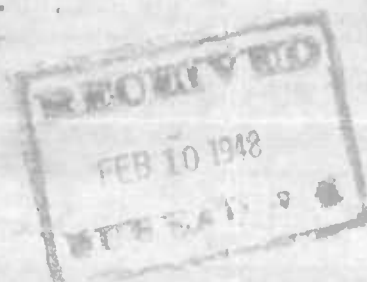
23. SIGNATURE... Date signed

Address... Date signed

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County... Kent
City or town... Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

108 Lynchburg St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Kent
City or town... Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ella Warren

3. (b) Social Security Number

no

4. Sex

female

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widowed

B. (b) Name of husband or wife

Wm. Warren

7. Birth date of

deceased (mo., day, yr.)

Jan. 25, 1864

8. AGE:

Years

84

Months

0

Days

11

If less than one day

hrs.

min.

9. Birthplace

Kent Co. Md.

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Home

MOTHER

FATHER

12. Name

Shade Brown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Personal Bible

Address

108 Lynchburg St.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb.

1948

(month) (day) (year)

Cemetery or crematory

Quaker Neck (col.) Cem

Location

Chestertown, Md.

18. Funeral director

J. Willis Wells

Address

Chestertown, Md.

19.

Feb. 7 1948

1948

Clara S. Barnes

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb. 6, 1948, 19 at 12.30 A

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Did not attend Investigated death signed
Certificate as Deputy Med. Exam. Kent Co.

Immediate cause of death

Myocarditis

DURATION

no of

yrs.

Due to

Arteriosclerosis

No. of Yr

Due to

Other conditions

(Include pregnancy within 8 months of death)

None

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

None

Injured at work?

23. SIGNATURE

Deputy Med. Exam. Kent Co. Md.

M. D. or other

Address

Chestertown, Md

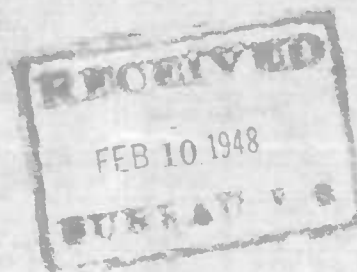
Date signed

2/6/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:

County Kent
 City or town Galena R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Galena R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Samuel M. Yingling

3. (b) Social Security Number

YES

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Helen J. Yingling
living 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept. 21, 1874
 8. AGE: Years 73 Months 4 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Georgetown, Virginia
 (Town, county, and state)
 10. Usual occupation retired farmer
 11. Industry or business _____

FATHER 12. Name Jacob Yingling
 13. Birthplace Maryland
 MOTHER 14. Maiden name Ida Burns
 15. Birthplace Maryland

16. Informant Mrs. Helen J. Yingling
 Address Galena, Maryland

17. Burial Burial Date thereof Feb. 13, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory CHESTER CEM.
 Location CHESTERTOWN, MD.

18. Funeral director J. Willis Wells
 Address Chestertown, Md.

19. Feb. 10 19 48 Elizabeth J. Muford
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1948, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 46 to Feb. 10 19 48

and that I last saw him alive on February 10, 1948

Immediate cause of death Coronary thrombosis DURATION 3 yrs.

Due to Arterio sclerosis

Due to _____

Other conditions Gen. art. sclerosis 10 yrs +
Chr. nephritis 2 yrs.
 (Include pregnancy within 8 months of death)

Major findings of operations _____

Antemortem results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James H. Papaschi, M.D. M. D. or other _____

Address Galena, Md. Date signed 2/10/48

